(a) The assets must be identifiable and recorded in the provider's accounting records.

(b) The depreciation must be based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets. Fair market value shall be determined based on the lesser of at least two bona fide appraisals. Costs should be capitalized in accordance with Generally Accepted Accounting Principles.

(c) Depreciation must be prorated over the estimated useful life of the asset using the straight-line method. The estimated useful life of a depreciable asset is its normal operating or service life to the provider subject to the provisions in CFR 413.134(b)(7)(i), (ii), and (iii). Providers must use the useful life guidelines published by the American Hospital Association, as specified in Medicare HIM 15. A different useful life may be approved by the intermediary if the provider's request is properly supported by acceptable factors that affect the determination of useful life.

(d) Centers that previously did not maintain fixed asset

records and did not record depreciation in prior years will be entitled to any straight-line depreciation of the remaining useful life of the asset.

(e) Leasehold improvements may be depreciated over the lesser of the asset's useful life or the remaining life of the lease.

(f) Gains and losses realized from the bona fide sale or scrapping of depreciable assets are included in the determination of allowable depreciation cost. If the total amount of gains or losses realized from bona fide sales or scrapping does not exceed $5,000 within the cost reporting period, the net amount of gains or losses will be allowed as a depreciation adjustment in the period of disposal. Other gains and losses will be treated in accordance with CFR 413.134(f).

(g) The fixed asset records shall include for each asset: a description, the date acquired, estimated useful life, depreciation method, historical cost or fair market value, salvage value, depreciable cost, depreciation for the current reporting period, and accumulated

TN 90-08 SUPERSEDES TN NEW
DATE RECEIVED SEP
DATE APPROVED 11/12/92
DATE EFFECTIVE
AUG

depreciation.

3. Travel Expense. Travel expense is allowable to the extent it is related to patient care and is for the operation of the FQHC. For example, travel by physicians and other FQHC staff between the related satellite FQHC's is allowable expense.

E. Terms which are used in defining allowability of costs are defined for purposes of this plan as follows:

1. Necessary - means that the purchase is required for normal, efficient, and continuing operation of the business.

2. Costs related to patient care - These include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of the FQHC and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, staff costs, maintenance

costs, administrative costs, and others.

3. Cost not related to patient care - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of FQHC services and activities. Such costs are not allowable in computing reimbursable costs. For example, travel expense is not allowable unless it can be specifically shown that it relates to patient care and to the operation of the FQHC. Entertainment expense is not considered related to patient care and, therefore, is never allowable.

4. Related to provider - means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

5. Common ownership - exists when an individual or individuals possess ownership to the extent that significant control can be exercised.

6. Control - exists where an individual or an organization

had the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

7. Prudent buyer - A prudent buyer is one who seeks to minimize cost when purchasing an item of standard quality or specification.

2-2 NON-ALLOWABLE COSTS

A. Bad Debts. Bad debts and costs directly associated with bad debt collection.

B. Community Service. Costs incurred for public relations, public education and similar activities.

C. Contributions. Contributions made to political parties, candidates or any organization are not allowed. Other contributions are not allowable.

D. Entertainment Costs. Costs for entertainment or amusement.

E. Interest and Penalties. Interest and penalties imposed by the government or courts.

F. Legal Expense. Legal costs and fees resulting from suits against Federal-State agencies administering the Medicaid Program or their agents.

G. Outreach. Outreach expenses such as establishing and maintaining community relations and good will.

H. Reference Laboratory Costs. Medicaid requires that the provider rendering the laboratory service bill for that service. Therefore, reference laboratory costs are not an allowable cost to FQHC's.

I. Unauthorized Services. Costs associated with services the FQHC is not licensed or authorized by State law or licensing agencies to provide.

J. Non-covered Services. Costs for services not defined as core services or other ambulatory services otherwise provided under the State Plan.

K. Donations. The imputed value of donated goods or services received, unless services are performed by nonpaid workers who work more than twenty (20) hours per week in various types of full-time positions that are normally occupied by paid personnel of the center and when the center is not operated by or related to religious orders.

Certain expenses and revenues are excluded because they are not normally incurred in providing patient care.

Expenses to be excluded:

a. Non-working officers' salaries

b. Fund raising expenses for capital and replacement items

c. Parties and social activities not related to patient care

d. Organization membership not related to patient care such as country clubs, tennis clubs, etc.

e. Gift, flower and coffee shops

f. Vending machines

2-3 REDUCTIONS TO ALLOWABLE COSTS

A. Investment income on unrestricted funds will reduce interest expense. This applies only to the interest expense portion of allowable costs.

B. Grants, gifts, and income designated by the donor for specific operating expenses should be used to offset the specified center expenses. For purposes of this requirement, unrestricted grants, gifts, and income are to be considered not designated for specific operating expenses.

C. Recovery of insured loss

D. Sale of medical and surgical supplies to other than patients.

E. Sale of medical records and abstracts.

F. Sale of x-ray scrap

G. Space rented to employees and others.

I. Sale of drugs to non-patients

J. Payments received from specialist.

K. Trade, quality, time and other discounts on purchase.

L. Rebates and refunds of expenses.

Generally, the cost of many of the above items should be eliminated. In lieu of determining costs, the related income may be used to offset costs.

CHAPTER 3

CORE SERVICES REIMBURSEMENT RATE COMPUTATION

3-1 RATE COMPUTATION - GENERAL PRINCIPLES

The objective of the prospective rate computation is to provide a rate to be reimbursed to the provider for core service visits billed to the Division of Medicaid for Medical Assistance recipients. The prospective rate is not an all-inclusive rate to be used for reimbursement of non-core services. Also the prospective rate is not the Medicaid rate per visit reported on the cost report and used to determine cost settlement. The computation of the prospective rate is based on information reported in the provider's annual cost report and also includes a trend factor, which serves as a forecasted economic indicator for FQHC's.

3-2 THE RATE COMPUTATION

The prospective rate for reimbursement of core service visits will be computed using the Medicaid cost report data after desk review. Only factors related to core services will be considered in determining the rate. The direct core services costs as well as the allocable indirect core services costs reported as overhead costs will be considered. The computation will be as follows:

A. Determine the total core services adjusted expense.

1. Ascertain the core services total adjusted expense reported.

2. Allocate the overhead expenses to core services. The percent of core services total adjusted expense to Total adjusted costs will be multiplied by the allowable overhead cost as determined on the cost report.
3. Add together the direct and indirect core services adjusted expense for the total.

B. Determine the visits applicable to core services.

1. Ascertain the physician and midlevel visits used in the cost report rate determination
2. Ascertain the number of all visits reported for clinical social workers and clinical psychologists
3. Add together the visits determined in 1 and 2, above.

C. Determine the cost per visit for core services.

1. Divide the total core services adjusted expense determined in A. above by the core service visits determined in B. above.
2. Carry the cost per visit to the second decimal place.

D. Ascertain the outstationed/eligibility worker cost addend from the cost report.

E. Determine the core services reimbursement rate.

1. Combine the cost per visit for core services from C. above and the outstationed/eligibility worker cost addend from D. above.
2. Apply the trend factor to the reimbursement rate from 1. above.